fluMist® Influenza Virus Vaccine Live, Intranasal — Ordering Instruction Sheet

1. If you are a **current GIV customer**, you only need to complete the **FluMist order form** and **Shipment Authorization form**.

2. If you are **not a current GIV customer**, you must **complete all of the attached forms**.

3. It is important that you **complete ALL fields of every form** to ensure your order is processed quickly.

4. FluMist is a frozen product and must be stored in a regular household, frost-free refrigerator freezer combination unit. FluMist cannot be stored in a dormitory-style refrigerator freezer.

Before returning your forms, please review this checklist to ensure you have everything necessary.
Your order will not be processed unless all information is complete.

Existing Customer

- ❒ Provide your **fax number** on Order Form
- ❒ **FluMist Order Form** *(New and Existing Customers)*
- ❒ Include a copy of your current **State Medical License, Pharmacy License/Permit or the DEA Certificate**
  - New and Existing Customers *(State of FL customers, State License is required)*
- ❒ **Shipment Authorization Form** - Complete if the address on your license does not match your Ship-to address

New Customer

- ❒ **New Account Application** - Complete if you are not a GIV customer
- ❒ Tax Status: **Exempt** or **Non- Exempt**
  (If Exempt, please fax Exemption Certificate)
- ❒ Provide **Name of Owner** *(New Account Application only)*

FAX COMPLETED FORMS TO 866-314-7717

GIV® Fax Order Form for fluMist® Influenza Virus Vaccine Live, Intranasal

General Injectables & Vaccines, Inc.
80 Summit View Lane • P.O. Box 9
Bastian, Virginia 24314-0009

Bill To:
Name: _____
Address: _____
City: _____
State: _____ Zip Code: _____

Customer Number: _____
Customer Phone Number: _____
Customer Fax Number: _____
Contact Name: _____
Date Ordered: _____
Purchase Order Number: _____

Ship To: (Business Address Only)
Name: _____
Address: _____
City: _____
State: _____ Zip Code: _____

Payment:
❒ **On Account** (Payment Terms: 2% 45 days, Net 46)
OR
❒ **Credit Card** (A representative will call you)

Other Shipping/Billing Requirements
(Special Instructions) _____
_____

Office Hours: _____
_____
_____

Returnable Doses ($24.50/dose)

❒ ***I would like to order 20 Returnable Doses ($490.00/20 doses).***
Limited to ONLY 1 order per customer of 20 doses per ship-to-address, per season.

Non-Returnable Doses (under 50 doses $19.95/dose, 50 or more $18.95/dose)

Circle the number of doses you would like to order below. Quantities are fixed. Please circle only one.

20 doses ***$399.00***	***50 doses*** ***$947.50***	***70 doses*** ***$1326.50***	***100 doses*** ***$1895.00***	***120 doses*** ***$2274.00***
150 doses ***$2842.50***	***200 doses*** ***$3790.00***	***250 doses*** ***$4737.50***	***300 doses*** ***$5685.00***	***400 doses*** ***$7580.00***

Enter Quantity Over 400 here (in multiples of 50 doses):_____ **Requested Ship Date:____/____/____**

MedImmune Rep Name: _____ **Rep Phone Number:** _____

Prices do not include Federal Excise Tax (FET) or any other applicable taxes. Due to market conditions, prices and products offered are subject to change without notice. January 1, 2005. Price is based on volume. Prices indicated are per ship-to, per order.
A representative will call to confirm your order and shipping instructions prior to shipment.
NOTE: FluMist is a frozen product and must be stored in a regular household, frost-free refrigerator freezer combination unit. FluMist cannot be stored in a dormitory-style refrigerator freezer.

A pre-book order requires no financial commitment and can be modified or canceled at any time.

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If you have questions, call us at 877-FLUMIST. Hours of operation 8:30EST - 6:00EST

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NEW ACCOUNT APPLICATION

Customer # _____ *Date* _____ *CSR* _____

PLEASE FILL OUT COMPLETELY. WRITE N/A WHEN NOT APPLICABLE. ALL FIELDS ARE REQUIRED.

BILL TO

Legal Name of Practice / Pharmacy _____ Owner _____
Physician / Pharmacist's Name _____
Address _____ Federal Tax ID No./SS# _____
_____
City _____ State _____ Zip Code _____
Phone Number: ( ) _____ Fax Number: ( ) _____
Email Address: _____ County: _____

SHIP TO

Legal Name of Practice _____
Physician's Name _____
Address _____
_____
City _____ State _____ Zip Code _____
Phone Number: ( ) _____ Fax Number: ( ) _____
Email Address: _____ County: _____

Type of Practice-Medical (Please check only one box)

- ❒ Ambulance/EMS
- ❒ Dialysis
- ❒ Laboratories
- ❒ Mid Level Practitioner
- ❒ Pharmacies
- ❒ Surgi-Centers
- ❒ Clinics
- ❒ Government
- ❒ MD's/DO's
- ❒ Medical imaging/X-Ray/Radiology
- ❒ Physical Therapy/Occupation Health
- ❒ Universities/Schools
- ❒ Dentists
- ❒ Health Depts
- ❒ Misc. Taxable Customer
- ❒ Nursing Home Centers
- ❒ Podiatrists
- ❒ Visiting Nurse/Homecare

Specialty Type _____ **Tax Status* _____

(See List On Back)

Contact Person

Name of Purchaser:
Last Name: _____ First Name: _____ Title: _____

Accounts Payable Contact:
Last Name: _____ First Name: _____ Phone: ( ) _____

Is PO required? ❒ Yes ❒ No

DEA / State License Requirements

DEA Number: _____ DEA Expiration Date: _____

State License Number: _____ State License Expiration Date: _____

We must have a copy of either the state medical license, pharmacy license / permit or the DEA Certificate. Florida accounts are ***required*** to submit a copy of their state license. We must have a copy on file to be in compliance with federal and/or state regulations.
Fax number: _____ Florida Statute Section 499.0121(6)(a)2., requires the state license, permit or registration number of the person authorized to purchase prescription drugs to appear on the transaction documentation.

*If non-taxable, please provide a copy of the resale certificate or exemption form. **By completing this new account application, the customer agrees and understands that we may use the fax number(s) and/or email address provided in order to transmit advertised specials or other promotional materials.

Please write one in Specialty Type space on front of form.

Specialty Types		
ADVANCED REGISTERED NP	HEMATOLOGY	PATHOLOGY
ALLERGY	HMO	PEDIATRIC NURSE
ANESTHESIA	HOME HEALTH CARE	PRACTITIONER
CARDIOLOGY	HOSPITAL	PEDIATRICS
CHIROPRACTOR	INTERNAL MEDICINE	PHARMACY-CHAIN
CLINIC	LABORATORY	PHARMACY-CLINIC
DENTISTRY	MENTAL HEALTH &	PHARMACY-HOSPITAL
DERMATOLOGY	RETARDATION	PHARMACY-INDEPENDENT
DIAGNOSTIC CENTER	MIDWIFE	PHARMACY-UNIVERSITY
DIALYSIS	MULTI-PRACTICE	PHYSICAL THERAPIST
DIET CLINIC	NEPHROLOGY	PHYSICIAN ASSISTANT
EMERGENCY ROOM	NEUROLOGY	PLASTIC SURGERY
ENDOCRINOLOGY	NURSE MIDWIFE	PODIATRY
ENT /	NURSE PRACTITIONER	PRISON HEALTH SYSTEMS
OTORHINOLARYNGOLOGY	NURSING HOME	PROCTOLOGY
FAMILY PRACTICE	OB / GYN	PSYCHIATRY
GASTROENTEROLOGY	OB / GYN NURSE PRACTITIONER	PULMONARY
GENERAL PRACTICE	OCCUPATIONAL HEALTH	RADIOLOGY
GERIATRICS	ONCOLOGY	REHABILITATION CENTER
GOVT-CITY	OPHTHALMOLOGY	RETIREMENT HOME
GOVT-COUNTY	OPTOMETRIST	RHEUMATOLOGY
GOVT-FEDERAL	ORAL SURGEON	SURGEON GENERAL
GOVT-HEALTH DEPARTMENT	ORTHOPEDICS	UNIVERSITIES / SCHOOLS
GOVT-MILITARY	OSTEOPATH	UROLOGY
GOVT-PRISON / CORRECTIONAL	OTHER	VETERINARY
GOVT-STATE	PAIN MANAGEMENT CLINIC	VISITING NURSES

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Shipment Authorization Form

Must complete if desired shipment address differs from Medical License.

Attention : _____

Customer Fax #: _____

Customer Support Representative : _____

Please fax back to 1-866-314-7717
Make sure to fax a copy of your State License or DEA with this letter.

My shipping address is different than the address on my license. I have indicated my shipping address below.

Shipping Address Information:

Customer Number: _____

Physicians Name: _____

Street Address: _____

City, State, Zip: _____

I authorize GIV to ship Pharmaceuticals/Medical supplies to the above address. All prescription items will be ordered and used under my direction and supervision. I have enclosed a copy of my State License and/or DEA Certificate to verify my status as a licensed practitioner in the above state. I will notify GIV if there are any changes to this address or when it becomes inactive.

_____ _____

Physicians Signature *Printed Name*

_____ _____

Medical License Number *Dea Number*

** Schedule Drugs will only be shipped to the address on the DEA License.